NATIONAL QUALITY FORUM

Moderator: Benita Kornegay Henry
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Woman: This is NQF, folks. We'll be getting started in just a moment or two.

Christopher Stille: Hello, it's (Chris) Stille.

Samuel Stolpe: Hi, (Chris). This is (Sam) Stolpe with NQF here. We're going to be getting started in just one moment.

Christopher Stille: Okay.

Samuel Stolpe: Actually, I think that moment is upon us, so it's going to be 1 minute after the hour for everybody to - everyone to convene. Hello and welcome, everybody. This is (Sam) Stolpe with National Quality Forum. And you are on the Patient Experience and Function Spring 2019 Post-Evaluation Web Meeting Number Two Call.

I am joined by our two Co-Chairs. We just heard (Chris) Stille, but Lee Partridge is on the line as well. And we're looking forward to having a productive discussion.

We have a five-measure agenda ahead of us. And let me just give it just a really brief recap of where we are in this cycle. So, we have -- we had a total of 15 measures for us to tackle as a group together for this cycle, which I just really think that the committee and the Co-Chairs deserve an extra helping of thanks for taking on that task of itself.

But it was, of course, complicated by a related and competing pair of measures, or I should say two pairs of measures that we were able to get through in our in-person but left us with a couple of measures we still need to complete.

And I think we're just on the cusp of being able to finish up our work for this cycle. So, once again, big thanks to everybody for coming today and for all of your help in getting us through these 15 measures.

Okay, with that being said, let's go ahead and introduce the team. I know you're familiar with us, so just to remind you, we have three other folks on the call today.

Suzanne Theberge, who is our Senior Project Manager, (Aroma Equa), who just joined our team as our Project Manager, and Jordan Hirsch, who is our Project Analyst. Thanks to the team.

So, I wanted to do a roll call now. I've heard a couple of you on the phone, but I'm just going to go through and read the names. The larger point is that we're looking to achieve quorum, quorum for us is a total of 14.

If we don't reach quorum, we will not be voting on measures today, but rather, what we'll do is we'll send a follow-up email with a link to the recording and invite the remainder of the committee and yourselves, of

course, to vote virtually in order for us to achieve quorum based on the discussion that's inside of the recording, so we should be able to get at least a solid idea on what others are thinking about the measures and maybe achieve some consensus through that route.

So, let's -- without further ado, let's go ahead and go through our roll call. Lee Partridge, are you on the line?

Lee Partridge: Yes, I am.

Samuel Stolpe: Thank you, Lee. (Chris) Stille, I heard you.

Christopher Stille: Right here.

Samuel Stolpe: Beth Averbeck?

Beth Averbeck: Yes, I'm here.

Samuel Stolpe: Thanks, Beth. Don Casey? All right no Don? Ryan Coller?

Ryan Coller: I'm here.

Samuel Stolpe: Thanks, Ryan. (Sharon Croft)?

(Sharon Croft): I'm here.

Samuel Stolpe: Hello, Sharon. Chris Dezii? Okay. Shari Erickson? Dawn Hohl?

Dawn Hohl: Here.

Samuel Stolpe: Thanks, Dawn. Stephen Hoy?

Stephen Hoy: Here.

Samuel Stolpe: Thank you, Stephen. Sherrie Kaplan?

Sherrie Kaplan: Unexpectedly here.

Samuel Stolpe: Oh. And very happy to have you. Thanks, Sherrie. Brenda Leath?

Brenda Leath: Present.

Samuel Stolpe: Thank you. Brian Lindberg?

Brian Lindberg: Here.

Samuel Stolpe: Hello, Brian. Linda Melillo? Okay. Ann Monroe?

Ann Monroe: Here.

Samuel Stolpe: Hi, Ann. Lisa Morrise?

Lisa Morrise: I am here. I have a family issue brewing, so I may have to drop off at some point.

Samuel Stolpe: All right, thanks for the heads up. Just let us know when you do either via chat or just pipe up. Thank you, Lisa. I heard Terry O'Malley.

Terry O'Malley: Hello.

Samuel Stolpe: Hi, Terry. Deb Saliba? Do we have Ellen Schultz? Oh, no. Lisa Gale Suter?

Lisa Gale Suter: I'm here.

Samuel Stolpe: Okay, thanks, Lisa. Peter Thomas?

Peter Thomas: Present.

Samuel Stolpe: Okay. I think we've got a remarkably engaged group here, so thank you. We have achieved quorum. We're -- are we at 15?

Woman: Yes.

Samuel Stolpe: Fifteen. So, if you are going to step away, please let us know, that way, we can make sure that we're getting the adequate number of votes. But it sounds like we still have room for Lisa to drop off and we'll be okay.

Christopher Stille: Yes, and this is (Chris). I'll have to drop off at the top of the hour.

Samuel Stolpe: Okay. We'll -- that means we would lose quorum at some point during the call, so let's just -- everybody, keep things a little tight. If you're going to be stepping away, please let us know. Thank you.

Let's go ahead and go to the next slide. All right. I will do a quick walk through of the agenda. You should have that in your material to you as well. The first order of business is, of course, to get directly to the measures.

We have five measures listed on the agenda. We don't anticipate that we will be able to get through all of them but wanted to make sure that if we did make some significant progress, we could do as much work on this call. And if -- if

we're able to get through it all, obviously, we'll be able to cancel the call tomorrow.

So, our measures today are the two CAHPS measures that we weren't able to get to, Measure Number 0258 and 0517. And then we have three measures from CMS RNI and functional -- RTI on functional outcomes.

Some of which we started to address during our related and competing discussions, but this will be the remainder of the set of five. And I know we have some of our measure developers on the line, so we can actually just go ahead and head into the discussion around Measure Number 0258.

So, you should see that slide in front of you now that have the summary of it. I'll hand it over to our Co-Chairs to begin the discussion with the measure developers' introduction of the measure.

Christopher Stille: Lee, I'll run this one because I have to drop off.

Lee Partridge: Fine.

Christopher Stille: Okay. So, this is Measure 0258 from CMS Consumer Assessment of Healthcare Providers and Systems In-Center Hemodialysis Survey, also called ICH-CAHPS. So, I'll give you a couple of minutes to describe it for us.

Julia Zucco: Hi, this is Julia Zucco. I'm the Project Lead for ICH-CAHPS. On the phone is Dean-Whittaker, the Co-Lead, as well as (Liz) Goldstein, the Director of our Division.

We also have on the phone from our contractor, RTI International, our Project Director Amy Hendershott, Task Lead (Janelle Butler), and statistician Celia Eicheldinger, and Tracy Kline and Scott Scheffler.

ICH-CAHPS was first endorsed by NQF in 2007 and then re-endorsed in 2016. The survey is administered semiannually, in spring and in fall. We estimate that the administration of the survey costs the average facility about $1,500 per survey period.

The survey has given the patient receiving an in-center hemodialysis care from Medicare-certified dialysis facility. The patient population, mostly end-stage renal disease or ESRD patients are extremely ill and especially vulnerable, and we have a detailed manual that provides directions to protect our survey members.

The 62-item survey includes three composite scores, specifically the nephrologist communication and caring, quality of dialysis center care and operations, providing information to patients; and three global items, rating of nephrologist, rating of the dialysis center staff and the rating of the dialysis facility.

In 2018, there were over 200,000 completed surveys from over 6,800 facilities. The survey results are analyzed adjusted by patient mix and survey mode and top-box score as well as the five-point Star Ratings (as a tie).

Data is used for multiple purposes, including the CMS' ESRD Quality Incentive Program. They use the data to help determine facility payments, as well as the CMS dialysis facility compare. They display the top-box in Star Ratings on medicare.gov to assist in and patient choice as well to drive facility quality improvement.

Christopher Stille: Great, okay, thank you. I'd also ask anyone who is not speaking to try and mute their line because we get those -- I am one of those culprits.

Great. So, the lead -- the lead discussant is Lisa Suter and then Terry O'Malley and Stephen Hoy. Chris Dezii is not on the phone. I believe Terry is doing both (our). So, Lisa, would you like to start with our overview of what you thought?

Lisa Gale Suter: Sure, absolutely. So, I think a lot of general CAHPS issues were addressed last week during our meetings and calls in the weeks prior. So, I wouldn't go into those. I'm going to go specifically through a couple of concerns raised.

I think the NQF staff and I agree that the evidence criterion has been met although in my read, it's mostly based on data from other CAHPS measures that I think has had face validity extensions for the renal population.

There is a performance gap with documented disparities although a little confusion over interpretation of the measure results noted by one of the reviewers. So, just the take-home message for the developers for educational materials.

It was voted as acceptable, I think moderate reliability and validity by the scientific methods committee. There were comments from the reviewers highlighting some of the exclusions from the measure in terms of its validity.

It excludes hospice patients, disabled patients, non-English-speaking patients. And I agree, particularly hospice patients if you're undergoing dialysis, you may be hospice, but you're clearly -- you're clearly engaged enough in your care that you're continuing a fairly invasive procedure on a regular basis.

So, I think the argument for not engaging with them about their experience of their care is probably not as solid, and so, I agree with those criticisms or concerns.

There was data element validity provided and prior patient-focused groups during development that noted the value of the -- of the measure in sort of face validity of the measure.

There was discriminant construct validity testing in the place of empiric validity testing, which I was accepted by the Scientific Methods Panel, and I think it's acceptable, but I would like the measure, you know, given that it's come back.

This was the second endorsement maintenance cycle, but the next time, I'd like to see real, true, empiric validity testing against independent outcome that one would assume would be consistent with, you know, patient experience of care and (respect) from providers and things like that.

I know the patient experience measures don't always track really closely with outcomes, but I think that would be nice to see at least even directionally, as with all the HCAHPS measures or the CAHPS measures, the feasibility concerns, but this has been in use for a while and the costs are just cited.

Use -- it's in current use in the ESRD quality improvement program and dialysis facility compare as what's publicly posted. It passes a usability according to the NQF staff and I agree with that assessment.

I certainly think unintended consequences for some of the inclusions might be worth revisiting in the future. There was a comment from one of the

reviewers regarding 2623 as a competing measure, but I'm -- I don't actually think that qualifies as a competing measure because it has a slightly different population that it's focused on. So, that's -- those were my notes. And I'll pass it back over to the Chairs.

Man: Chris?

Christopher Stille: Sorry, I was on mute. Terry?

Man: (Unintelligible).

Christopher Stille: Terry, what would you like to add?

Terry O'Malley: I agree with everything Lisa said. I'd like to push a little harder on the exclusions because I think they are -- they're really excluding some of the most vulnerable populations who traditionally may not receive as consistent care or care that's consistent with their cultural beliefs.

So, I would really be interested in hearing the developers mention a little bit about how they're accounting for these exclusions. And I'd like them to answer whether they think surveying this group, perhaps not reporting it and folding it into the measure, but surveying them to see if they are materially different, and if so, and I think that would -- that would have the implications. Thanks.

Christopher Stille: Yes, sir. I think that's -- this is Chris. I think that's a good point because I know in other surveys that do include, for example, Latino or Spanish-speaking populations, there are real differences in perceived quality. Developers, would you like to speak to that?

Elizabeth Goldstein: So, which exclusions are you concerned about? Is it the hospice exclusion or ...

Terry O'Malley: Well, the hospice -- certainly, the hospice sort of stands alone but ineligible patients due the language barrier physically or mentally incapable?

Elizabeth Goldstein: Right. So, language barrier, the survey is translated in multiple languages. So, the reference is now, for example, there are Spanish translations of the survey. It's translated in many different languages. So, that's not one you typically get. It's, you know, if for some reason, facilities have not reported that they need a translation in a particular language then it would be, you know, included there.

Terry O'Malley: Oh, okay.

Elizabeth Goldstein: But we have facilities tell us they need translations. We make those translations for them. So, we don't want a facility to make their own translation because then the survey is not standardized. But that is not one that comes out a lot because we have lots of different translations.

Christopher Stille: Got you. And that was ...

Woman: That's helpful, thanks.

Christopher Stille: ... clarifying.

Elizabeth Goldstein: Yes.

Terry O'Malley: What would you ask the sort of the number though (unintelligible) that are still there?

Elizabeth Goldstein: I don't know if anyone on the phone from RTI or Julia or Debra know offhand. We can look it up for you but it's pretty small.

Terry O'Malley: Okay. As long as it's small then ...

Elizabeth Goldstein: Yes, as long as it's small. The hospice exclusion, this is a population, this is true for -- across many of our surveys. This is a population we used to include -- try to include in our surveys.

It's one that's super hard to get your responses from because it is a very -- I agree, it is a population that you would like to get responses to, but normally, in the last months of life, a hospice patient does not spend time, you know, doing surveys.

So, non-response becomes huge for this population. So, in this survey and for some of the other surveys, we do exclude them just because, you know, very few, you know, will respond because their focused, you know, on the last weeks, months of -- you know, of course, life.

And that sort of filling out a survey is not kind of a top priority during that period. So, we feel like we're, you know, being invasive if we keep calling them or sending mails, in particular, we keep calling or bugging the family and the patient when they're just trying to deal day to day, you know, with the last stage of life.

So, it is, you know, a decision we have made and, you know, I agree ideally, I think we all agree ideally, we will get their feedback, but, you know, we also want to be respectful of, you know, people up the end-of-life.

So, like for a hospice CAHPS survey, the one who filled it out is the family member or caregiver closest to the patient, you know, that it then sort of passing away.

Terry O'Malley: Okay, thank you, great.

Stephen Hoy: This is Stephen. Am I understanding correctly though that any survey considered by a proxy are excluded from the denominator?

Elizabeth Goldstein: Right. Normally, for this survey, it's a patient that is most aware of a care that they're getting. There is not a family member that, you know, normally sits through the patient during dialysis. So, if the patient that knows the care the best and that can answer it.

Christopher Stille: Okay. Stephen, any general comments while you're on?

Stephen Hoy: No, thank you.

Christopher Stille: Okay, good. Any comments from the committee about general things and we'll try to proceed category by category?

Don Casey: Hi, Don Casey. I just wanted you to know I'm on the phone. Sorry, I'm late. Are we -- which one are we discussing, can you remind me/

Christopher Stille: Thank you, Don. We're on 0258, dialysis.

Don Casey: In dialysis, thank you.

Christopher Stille: Great. Thanks for being on, Don, and that actually may save our quorum for when I have to drop off. Okay, good. Well, let's start -- let's start our voting

and then we'll discuss category by category after that. So, the first category is evidence.

Samuel Stolpe: This is NQF staff. We'll go ahead and pull up the voting. You should have links to both -- in an email that was recently sent to you as well as in the invitation itself.

Jordan Hirsch: The voting on evidence for 0258, CAHPS In-Center Hemodialysis Survey is now open. We're looking for two more votes. The voting on evidence for 0258 is now closed. The committee has passed evidence with 15 votes and 0 votes for no pass.

Christopher Stille: Okay. Then the next category is performance gap. As it's been adequately discussed, would anyone else like to talk about the performance gap? Okay. And we did discuss -- did we discuss about disparities also? We discussed the exclusions, but I didn't know if there was anyone else that wanted to talk about disparities that were found.

Lisa Gale Suter: Chris, this is Lisa. I think the only thing that I think is helpful to flag is that the measure adjusts for a lot of social risk factors, so I think just in terms of monitoring, it will -- it would be helpful to know -- you know, be sure that we're looking at adjusted -- you know, adjusted differences without social risks to understand sort of the disparities.

You know, there are documented disparities about sort of understanding how they're changing over time in response to measurement adjusting for some of the other known factors that influence CAHPS results, but without the social risk factors, I think it would be helpful to see in the future.

Christopher Stille: Yes, that's important. So, they're not just adjusted out of the -- of what we see. Great. Any other comments about disparities within the performance gap? Okay, well, let's vote on gap then.

Jordan Hirsch: The voting for performance gap for 0258 is now open. Your choices are A, high, B, moderate, C, low, or D, insufficient. The voting is now closed for performance gap for 0258. The committee has passed it with one vote for high and 14 votes for moderate.

Christopher Stille: Extraordinary. Okay, thanks, great. Next is reliability and validity. This measure wasn't examined by the Scientific Methods Panel, past reliability with rating of moderate and past validity with a rating of moderate.

Any discussants would like to talk about the scientific acceptability categories? Okay. Sherrie, any perspectives from the Methods Panel that are germane that you'd like to talk about?

Sherrie Kaplan: None and they've already been sort of discussed over our in-person and the other previous phone calls, so in ...

Christopher Stille: Okay.

Sherrie Kaplan: And I think the things move forward that the liability and validity issues are going to tighten up, but that's for the future.

Christopher Stille: Okay. Any committee comments about reliability and validity? Okay, well, let's vote to look at acceptance of the Scientific Methods Panel's conclusions then.

Jordan Hirsch: The voting for accepting the Scientific Methods Panel rating for reliability of moderate for 0258 is now open. The voting is now closed with 15 votes for yes. The 0258, has been upheld for a rating of moderate for reliability.

We'll now move to validity. The voting on the Scientific Methods Panel rating for validity for 0258 of moderate is now open. The voting for Scientific Methods Panel rating for validity of moderate for 0258 is now closed with the committee unanimously voting yes with 15 votes to uphold the rating of validity.

Christopher Stille: Very good. Feasibility -- all right, feasibility is next. And there were a couple of concerns from -- in the preliminary evaluation about usability. One was challenges with sampling due to the large number of facilities and the number of patients using the facilities being small, and the other was not talking about the need to use vendors to perform data collection and the associated time and costs.

However, in the summary just a few minutes ago, the developers mentioned the cost of about $1,500 per institution per period. So, that was addressed just now. Any concerns or what -- anything the discussants would like to talk about relating to feasibility? Lisa or Terry or Stephen?

Stephen Hoy: Can I have some help with the NQF framework? Is this where we would discuss any burden in health system and patient and families or is that for use and usability?

Christopher Stille: I think so. Stephen, you're a little bit fuzzy, but you wanted to discuss whether it was a burden for patient's family to facility, that I think this would be the right time.

Stephen Hoy: Yes. I think it holds true with a lot of the HCAHPS and patient experience (unintelligible) hearing a lot of burden on the health systems and the system -- the providers themselves and patients and families and they ask 60-somewhat questions about each individual experience within individual health care entity or your provider ...

Christopher Stille: I really can't hear.

Stephen Hoy: Oh, I'm sorry. I just wanted to bring up the fact that I have heard more overweighingly that these types of measures are a burden. And I just haven't heard that discussed by the committee. I'd be interested if any of my fellow patient/family advisers have suspected them a burden involved with this type of surveying?

Samuel Stolpe: That's Stephen, right?

Stephen Hoy: Yes.

Samuel Stolpe: Stephen, you may want to try calling back in. We can hear you but your line is really, really fuzzy.

Stephen Hoy: Okay. I'll try my best.

Christopher Stille: While Stephen is driving -- calling back in, any thoughts from the other discussants or committee?

Sherrie Kaplan: This is Sherrie. I am always concerned about the variation in response rate by vendors. You know, and my experience with other HCAHPS vendors, they often fall into the 15% response rate kind of category.

And I'm worried a little bit about especially when there's a low-volume situation, when you get into limitations on generalizability from that kind of response rate. Do the developers have any in any sort of sense of the variation in vendor response rates?

Christopher Stille: Go ahead, developers.

Elizabeth Goldstein: (Unintelligible) we weren't sure if we could answer. So, this is (Liz) Goldstein. Across from those CAHPS surveys, response rate is approximately 30%, so not 15%. It's sometimes will differ a little bit by vendor, usually not dramatically from vendor to vendor.

Sometimes, it just depends on what mode of survey administration they do. So, we always find mixed-mode. You know, mail followed by telephone has the highest response rate.

We are, you know, across all of our surveys, looking at ways to increase response rates. So, you know, we will be doing testing for all of these surveys once we get approval by -- you know, from the OMB looking at, you know, the Web mode and seeing if we could do a mix of Web followed by mail or telephone or some type of mix.

Sherrie Kaplan: Just one follow-up if I could that -- I wouldn't name the names of the vendor but we've had vendors through here and 15% is in the range, it's not 30% of the vendor.

So, there is variation and that was noted in the HCAHPS hospital measure that we earlier reviewed. But in the population where there are small numbers, they have a lower bound below which you're not estimating that a facility, and if not, are you using any kind of implication or what ...

Elizabeth Goldstein: So, if they -- for a very small facility, they are excluded from doing the survey. And if they don't have -- you know, and not complete, so I think it's 30 survey complete is not reported. So, we do look at that in each of the settings.

Sherrie Kaplan: Thank you.

Terry O'Malley: This is Terry O'Malley. Just a question, have you, guys, tried real-time surveying instead of in-facility survey?

Elizabeth Goldstein: Right. There is something we have thought about over time for in-center hemodialysis. This population is extremely vulnerable. This population, they are very concerned about retribution by the facility.

So, we'll get lots of letters from patients and we do follow-up to help the individual patients, but they are concerned about retribution by the facilities and given, you know, this is life-sustaining care, it's so critical, you know, for them.

So, we feel very strongly particularly in the setting that has to be outside the facilities. So, it's independent, you know, from the facility. And I think from what we've heard from patients, we prefer that also.

Lisa Gale Suter: This is Lisa. That's like -- I wonder if that in and of itself should be reported to CMS, you know, like that just feels like -- I mean the fact that patient -- a significant patient population is concerned enough about retribution to send in letters strikes me as in and of itself might be predictive of the patient experience.

Elizabeth Goldstein: Yes, we too. Anytime we get a letter (unintelligible) follow-up done people -- you know, we -- you know, my division gets a letter back, we send it to the various, you know, surveyors and (unintelligible)monitors their care in in-center hemodialysis facilities to make sure there are no issues, you know, going on or if there are issues for them to be addressed.

So, I think the survey us very important because it gives patients the ability to voice concerns as well as they will send in these letters where we can, you know, do separate from the survey follow-up on their care or if they (unintelligible) cried for help, we can call the CMS and, you know, help them.

But I think it's very important for a lot of these surveys, it's important that it's separate from, you know, where they're getting the care so they feel open and able to respond. They allow the staff person overlooking what they're writing or saying or that you need to make sure they feel like they can give an unbiased answer.

Brenda Leath: This is Brenda. I'm very glad that, Linda, you raised that point because I was (cringing)when I was listening. And I'm -- you know, it made me think that there needed to be some proactive way of addressing the patient's concern.

The question I have and this might be beyond scope, but is there a way of knowing what kinds of improvements have been made as a result of the follow-up that you -- that you are making from the survey?

Elizabeth Goldstein: So, there is always ...

Brenda Leath: And sort of ...

Elizabeth Goldstein: Yes. So, I think people in this setting as well as a number of our other settings, we know facilities are focused on the result to making approvement as well as, you know, if they are contacted by a survey or CMS, they're addressing the issue. So, I think, you know, it is very helpful for quality improvement when, you know, issues are identified or significant issues are identified.

Beth Averbeck: So, this is Beth Averbeck. I just had a question about comparing dialysis units because a number of dialysis units are small with potentially less than 50 shares and the response rate is 15% and they need a certain N size to be compared. Do you have an idea what percent of dialysis units across the U.S. might be included versus those that wouldn't meet that threshold?

Elizabeth Goldstein: I don't know if Julia, Debra or Celia know how many are meeting the threshold. Also that 15%, I don't think for most of our vendors, I'm not sure which vendors they are referring to, but for the protocols that we require that would be extremely unusual.

Woman: Yes.

Beth Averbeck: Okay. But what would be the N size that you would want (unintelligible) maybe that you needed about 50 responses for (unintelligible)?

Elizabeth Goldstein: So, it would be publicly reported, it's 30 survey complete.

Beth Averbeck: Okay, all right. Yes, I just not (unintelligible)numbers the dialysis units have 50 beds or 50 chairs or less, and so, it might be hard to get that threshold with that response rate even if you had a 30% response rate.

Elizabeth Goldstein: Even though it was 50 chairs, there's multiple people across ...

Beth Averbeck: Yes.

Elizabeth Goldstein: ... the (unintelligible).

Beth Averbeck: Yes.

Elizabeth Goldstein: They're not receiving, you know, 24/7.

Beth Averbeck: Yes, no, I get it.

Christopher Stille: Okay, good. Any other comments on feasibility? Thanks for that good discussion. All right. Well, let's vote on feasibility.

Jordan Hirsch: The voting for feasibility for 0258 is now open. Choices are, A, high, B, moderate, C, low, or D, insufficient. The voting is now closed for feasibility for 0258. The committee has not reached consensus with eight votes for moderate and seven votes for low.

Samuel Stolpe: So, eight votes for low, we had a correction.

Jordan Hirsch: Yes.

Samuel Stolpe: We're doing -- unless we're going with this, which is nine to seven. Sorry, there was a change in the vote, so it's nine vote for moderate, seven votes for low.

Christopher Stille: Okay.

Samuel Stolpe: It's still (CNR) but I will remind the committee that feasibility is not an NQF must-ask criteria.

Christopher Stille: Okay. Great. So, then the next category is usability and use, separate items. Comments from the discussants, Lisa or others?

Lisa Gale Suter: Nothing beyond what I mentioned earlier.

Christopher Stille: Sure.

Stephen Hoy: This is Stephen. Can I get a sound check?

Christopher Stille: Much better, thanks.

Stephen Hoy: Terrific.

Christopher Stille: Did you want to comment with that, Stephen, or just sound check?

Stephen Hoy: No.

Christopher Stille: Okay, sounds good. Yes, in the -- in the preliminary summary, there were no other significant concerns that I can see. Any other comments on usability and use from the rest of the committee?

Sherrie Kaplan: This is Sherrie again. Can I ask the question the NQF staff? The interrelationship between feasibility and usability, I guess the two constructs are different. On the other hand, can you -- can you be feasible but not usable or the reverse, not feasible and usable?

Samuel Stolpe: Hi, this is Samuel at NQF. And I'll just chime in briefly on that. They -- you're right that they are very complementary concepts. So, feasibility, we do a lot of looking at burdens.

And when we're -- when we're talking about usability, the things that fall into that are twofold, one, unintended consequences as well as the performance over time. So, while those are kind of related, they do evaluate some different things.

And -- but the answer to your question is, yes, so they can -- they are somewhat connected but they also have some mutually exclusive elements to them that you could be feasible i.e. the burden as well. But it might not have high usability because of large synthetic consequences or failure to introduce performance improvement over time.

Sherrie Kaplan: Thanks.

Don Casey: This is Don. Can you hear me?

Christopher Stille: Yes.

Don Casey: I apologize, I had (unintelligible) so forgive me. I want to comment about this possibly (unintelligible)you haven't seen or heard the term shared decision-making involved in (unintelligible)especially (unintelligible).

Christopher Stille: Don, we can't understand you.

Don Casey: I'm sorry. (Unintelligible).

Christopher Stille: Okay.

Samuel Stolpe: Don, if you wanted to share your comment via chat, the NQF staff would be happy to read it. Sorry, we can read this a bit later if you'd like.

Woman: Okay.

Samuel Stolpe: But in the meantime, perhaps we should go ahead and move forward to any other comments somebody may have.

Woman: (Unintelligible).

Samuel Stolpe: Okay.

Jordan Hirsch: NQF 0258 usability is now open for votes. Your choices are, A, pass, B, no pass.

Christopher Stille: Okay, did Don decide not to submit a comment by chat?

Man: We didn't see ...

Don Casey: No, I'm just -- I'm having a lot of technical problems with the different centers.

Christopher Stille: Okay, I'm sorry. Okay, sorry. So, you're okay with the phone, okay.

Jordan Hirsch: Voting for use is now closed for 0258. The committee has passed with 14 votes for pass and two votes for no pass.

Christopher Stille: Okay. And then usability.

Jordan Hirsch: Usability for 0258 is now open. Your choices are, A, high, B, moderate, C, low, or D, insufficient. Voting on usability for 0258 is now closed. The committee has passed usability with 13 votes for moderate, two votes for low, one vote for insufficient.

Christopher Stille: Very good.

Man: Thank you.

Christopher Stille: Great.

Man: Well, go ahead.

Christopher Stille: Should we vote on overall or any other last comments?

Samuel Stolpe: if there's no more comment, let's go ahead and vote.

Christopher Stille: Okay.

Jordan Hirsch: The voting for overall suitability for endorsement for 0258 is now open. Your choices are. A, yes, or B, no. The voting for overall suitability for endorsement for 0258 is closed. The committee has recommended the measure for maintenance of endorsement with 16 votes for yes, zero votes for no.

Christopher Stille: Okay, great. (Unintelligible).

Samuel Stolpe: All right. Well, big thanks to the committee and the developers for that. And let's go ahead and move on to the next measure which is CAHPS Home

Health Care Survey Measure Number 0517. Chris, I know you need to drop off at 3:00. Did you want to hand it over to Lee or ...

Christopher Stille: Yes, that sounds good, Lee, if that's okay with you.

Samuel Stolpe: Of course. Lee, you're up, but first of all, I'll hand it over to our measure developer to introduce their measure.

Lori Teichman: Thank you. Hello, everyone. Thank you for participating today. I'm Lori Teichman, Contracting Officer's Representative for national implementation of the Home Health CAHPS Survey.

And joining me today from RTI International, the federal contractor for the national implementation of Home Health CAHPS are Drs. Carla Bann, Wayne Anderson and Harper Gordek.

Home Health CAHPS data collection began in 2010 on a continuous monthly schedule and CMS requires the data in a home health payment program since 2012. Public reporting of Home Health CAHPS data began in 2012 on Home Health Compare, the tool on medicare.gov.

And we added Star Ratings in 2016. There are five measures that a publicly reported care of patients, communication between patient and provider, specific care issues, overall rating of care and would you recommend the agency to family and friends.

Every year, about 8,500 home health providers participate Home Health CAHPS and we annually received about 1.6 million completed surveys from patients receiving home health care.

Excuse me, I'm sorry. All 28 approved Home Health CAHPS Survey to vendors conduct the survey in English and Spanish, all survey vendors are required to be able to conduct the survey in English and Spanish.

Some vendors conduct the survey in additional languages. Home Health CAHPS is conducted in one of three modes -- mail-only mode, telephone-only mode or mail with telephone follow-up mixed-mode. And most of these surveys are conducted with the mail-only mode. The cost of data collection is approximately $3,000 annually.

Home health is a dynamic industry and it is constantly changing, it is a constantly changing provider community and there is significant staffing turnover within the agencies. The number of providers notably changes from year to year.

Moreover, based on the number of patients, some home health agencies are not required to participate in Home Health CAHPS every year. Thus, it is more difficult to show national trends and improvements given that dynamic nature.

We have seen small increases over time nationally and we do see variation across agencies. We see improvements in average year-over-year scores for individual items that make up the multi-item measures over time.

There are many organizations that have set up training programs and quality improvement guides focused on the Home Health CAHPS Survey, and individual agencies implement the quality improvement activities to improve results and they do see changes in scores when they implement these activities.

Finally, unique to the home health industry, nurses and therapists work alone in homes. They do not have the support of other staff day to day, and they often work in difficult environments that are not set up for the care of patients. Thank you. Thank you very much. Dawn, I believe you're our lead discussant. Would you like to start us off?

Dawn Hohl: I sure would. Thank you so much, Lori. That was really helpful. I think overall that the evidence that was provided in the update was strong. There was very good linkage between the logic model and the five dimensions of the domains, and the global linking to patient behaviors.

I think part of the challenge -- and I don't know if Lori or our colleague from RTI can help fill us in. The data that was included in the packet only focused on 2017.

And that we were looking to show improvement which was mentioned, we can't link any empirical evidence and I'm wondering if that's available.

Lori Teichman: Developers?

Elizabeth Goldstein: Hello, this is (Liz) Goldstein. I'll start and then RTI can add. So, the improvement, I think what Lori was trying to say, it's hard to see at the national aggregate level because the industry is (unintelligible).

So, there are a lot of agencies that go in and out every year. It's not a -- like for a lot of our other providers, it's a stable population from year-to-year. This is not a stable population from year-to-year. Agencies are coming and going, there are staffing turnover, rarely significant staffing turnover at home health agencies and the smaller agencies.

Some of them come in and out depending on their home health patient, you know, counts from year-to-year. So, for improvement, we see when an agency implements quality improvement and activities. They do see, you know, changes in the score.

Nationally, we are seeing some changes in the individual items that make up the multi-item measures. But it's hard to see it at that aggregate level if that helps.

Dawn Hohl: No, I think that makes sense and that's part of my struggle when I try to apply the NQF standard. You know, there's a lot of information here, but if there's no empirical evidence, which I think is okay if we have enough, you know, other evidence within the domains.

The other question, and I don't know if it's here or better underused. And I can -- I have some other questions as we go through the process. So, I'll put this one out there.

It was, there was mention in the report that feedback was sought, and I think it was sought from the patients. But I wonder if there is any detail on how that feedback -- what was the mechanism to solicit feedback and were there any trends as well as to -- was there feedback sought from agencies and/or vendors? I wonder if there was any lessons learned that we should be capturing.

Elizabeth Goldstein: So, for -- you know, we can -- let me start and others can add. So, we did recently get feedback from patients through focus groups as well as from cognitive interviews.

And for that feedback, we were trying to understand, you know, whether that current instrument is, you know, sort of having tweaks in the future. I think what we saw is most of the topics covered by Home Health CAHPS are still relevant.

There are maybe, you know, some tweaks as we, you know, look to improve the instrument that we'll be testing in the future. So, that would be kind of for our next endorsement if we make any changes.

We regularly get feedback from vendors when we do site visits. So, they were asking, you know, if they're having any particular issues. We also see most of the vendor have set different quality improvement programs, so they are providing, you know, some guidance or advice to agencies about how do we improve scores. So, there's a lot of material, you know, out there to help agencies focus on improvement.

Dawn Hohl: Okay and great. And I think the last time, and I'm trying to also bring in any other comments that have been brought forward. There was mention in there and comparing some of these with heated measures.

And I know with home health that the clinical measure is OASIS. So, I was curious whether there were any type of metric that would help us understand the true clinical outcomes and how the patient experience may or may not be improving the ultimate performance.

Lori Teichman: So, this is Lori again. Was it HEDIS or OASIS?

Dawn Hohl: You know, in my notes, it said, it's comparing it to HEDIS. But my -- and maybe it's a typo, I don't know. But my world would tell me in home care, we would be looking at OASIS.

Woman: Right, yes.

Woman: I think it is OASIS.

Dawn Hohl: Okay. And maybe that's a typo though. So, somewhere in the notes, I picked that up and it just didn't make sense to me. And I know that Ryan, Linda and Don are also discussants on this, so I don't want to monopolize the whole conversation. But they were the beginning comments.

Elizabeth Goldstein: So we could ...

Man: Yes,

Elizabeth Goldstein: Yes, we could -- Wayne, if you want to talk a little bit about some of the analyses RTI did related to that.

Wayne Anderson: Thank you, (Liz). Wayne Anderson at RTI. So, we actually did look at this several years ago in a factor analysis where we pulled up a number of the OASIS measures.

And we're trying to see if the domains were common across OASIS items, and I think there is like a dozen of those versus our CAHPS measures where, you know, you've got the two global items with the other regrouped measures.

And for the most part, the two domains, the clinical one versus the patient satisfaction one, are complementary. There wasn't particularly much overlap at all and it pretty much identified the value for CMS to go forward and continue with the patient satisfaction experience given that lack of overlap. They're really speaking across two different domains.

Dawn Hohl: Interesting. Thank you, thank you. They were the opening comments. So, we have some comments under each section but I don't know if Ryan, Linda or Don wanted to add anything here.

Lori Teichman: Ryan?

Ryan Coller: No, thank you.

Man: Ryan, I had two sort of general questions that I don't think have a huge impact on the rating outcomes necessarily, but I'd be curious what the developers have to say about them and maybe where things are moving forward.

One was, given that I think some of these agencies take care of patients across the lifespan, I'm curious if there's any work developing on extension of the tool down to pediatric age population.

And then separately, just to provide a little bit more education on the choice of the two-month look back and how that has been the standard but ...

Elizabeth Goldstein: So, the -- let me try to address both of those. So, the two-month look back is really just to make sure the patient has enough experience to really provide an evaluation or discuss their experiences because in some cases, a nurse or, you know, a physical therapist are not regularly coming, you know, to the home.

So, we want them to make sure they have, you know, more than -- you know, sometimes, they will come out and do one visit, assess the person in that way.

Woman: Yes.

Elizabeth Goldstein: Really not providing care. So, there have not been discussions to-date about extending this survey to the pediatric population. Probably -- and this is just my own personal thoughts, so I could be wrong -- probably it was extended to the pediatric population. There probably need to be some, you know, tweaks to the survey just, you know, how do you deal with, you know, a child versus some health care. It's probably a little different and then they're also dealing, you know, with a parent that, you know, caring, you know, for the child. So, my guess is that, you know, there would be some tweaks.

There are not -- I think in a lot of cases, not all agencies are also serving the pediatric population. So, that also, you know, may create, you know ...

Man: Pediatric symptoms, research conditions and more, check it out at childrenscolorado.org.

Elizabeth Goldstein: I think someone was trying to talk.

Woman: True.

Woman: I think (unintelligible).

Elizabeth Goldstein: Okay, okay. So, we haven't discussed, you know, extending it to the pediatric population, but I - actually, I have a son who receive home healthcare every week and been receiving them for almost two years. So it's actually something I'd be very interested in, so it would be interesting so.

Lee Partridge: Right. Don, are you plugged in? Okay, wait.

Don Casey: Yes, I am and I'm in a Starbucks, so I apologize (unintelligible) to listen back. And I - can you hear me?

Lee Partridge: We can hear you. We're just having …

Don Casey: Hello?

Lee Partridge: … some background noise. Do you have any comments?

Don Casey: Can you hear me okay?

Man: Go ahead.

Lee Partridge: Don, we can't. Right. I think we lost - we lost Don again.

Don Casey: Are you - are you able to hear me or not?

Lee Partridge: We can hear you, Don.

Don Casey: Okay. Sorry I'm in a -- in a coffee shop. Two points I'm trying to make. One is unlike other measures I had a very hard time with this one because I couldn't get any sort of easy access to (unintelligible). I try the other - the other measure developers actually (unintelligible) and get a view on the CMS website.

And secondly, just related to this notation of this being outcomes measure, you know, when I look at the question, you know, there may be a couple in here that you could - you could relate to that, but sometimes we specifically back to tracking to the OASIS measures, which are designed to measure the

functional status and quality of life in actual terms. That is a - that is a measure that - and observation towards our patients.

Questions like when you first started getting home healthcare from this agency, if someone from the agency tell you what care and services you can get, yes or no, is the first stretch. Health status case reporting outcomes (unintelligible).

And so there's two things. Actually, I had a very hard time responding to this so …

Woman: Okay.

Don Casey: … that was pretty structured.

Lee Partridge: Thank you, Don. And if further - I'm going to open it up now for the full committee for comments before we start.

Ann Monroe: Lee, this is Ann Monroe. Could you just briefly summarize what he said? It was almost impossible to hear with the background noise. What were his two specific comments?

Sam, can you - can you help us? I know …

Ann Monroe: Or (Stephanie).

Samuel Stolpe: Yes.

Lee Partridge: I thought - okay.

Ann Monroe: Go ahead.

Samuel Stolpe: Don just some expressed concern that it was very challenging to find year-over-year data, and that's a critical element for us to determine whether or not the measure is, in fact, having the impact that we're hoping it will. And it was - it was just simply an expression of concern and wanted to see if the committee also have some reactions to that.

Lee Partridge: And I think he had a second point about one of the questions.

Samuel Stolpe: And that was when I had a little trouble with as well.

Lee Partridge: Right. I think he felt that it wasn't - the question didn't really go to the point. But maybe Don can - if you can type into the chat a little bit detail, Sam can then pick it up. But in the meantime …

Dawn Hohl: But I think the question - oh, I'm sorry. This is Dawn. I think the question he was struggling with was when the - when he first started receiving home health, did someone from the agency tell you what care and services you would get? I think that's what he said.

Samuel Stolpe: Right, it was an (intake) question, but he didn't think was, I don't know, I don't want to say significant, but it didn't seem to relate to the kind of measurement we were looking for.

Lee Partridge: Right, yes.

Don Casey: Yes, if - I - in fact, it was not indicative of related to health status.

Woman: Yes, yes.

Don Casey: Is the outcome related to a transaction, which to me is not …

Woman: Yes.

Don Casey: … it's worth something, but (unintelligible) reality of the patient itself.

Lee Partridge: All right. Comments from other members of the committee, comments or questions or concerns?

Sherrie Kaplan: Lee, this is Sherrie.

Lee Partridge: Oh, (unintelligible).

Sherrie Kaplan: (Unintelligible)inappropriate to ask a question about the - sort of disparities here or is that the next topic?

Lee Partridge: If you think it's relevant for the general discussion, Sherrie, go head and ask it here. Otherwise, we'll hold until we get to that point in the - in the verdict.

Sherrie Kaplan: Well, I just had a couple of quick questions. One is the issue of health literacy because I think I understood the developers to say it's a male service approach in large part. And so the question in vulnerable populations is health literacy and issuing the completion of this, how many people get excluded because they can't read or they don't have access to something that would help them with that. And then the differential access to home healthcare services that (unintelligible) in the - in the general strategy for a method.

Lee Partridge: Okay. (Liz) and RTI folks, do you want to respond?

Elizabeth Goldstein: So the survey is available currently in mail and telephone. So based on their population, home health agencies decide to do mail, telephone or a mix of mail or telephone. Normally, across all of our providers in various settings is - you know, it's a lower literacy, you know, population. They tend to do more telephone than mail surveys. This population tends to be a much older population relative to our other surveys. Average responded and (unintelligible) they are mid-70s.

Lee Partridge: And there's a cognitive screen. What do you do if the people fail it?

Elizabeth Goldstein: So there is not a cognitive screen before they start the survey. So if they're doing a - like telephone survey and they cognitively or unable to do it, then - and there's no proxy. Proxies are allowed for the survey.

Lee Partridge: Right.

Elizabeth Goldstein: Then, you know, it wouldn't be completed.

Lee Partridge: Thank you.

Elizabeth Goldstein: And the RTI, do you have anything to add?

Wayne Anderson: This is Wayne Anderson. So there's two ways that we account for that in case mix adjustment. One, we're screening for diagnoses of dementia and schizophrenia. And so we actually control for that in case mix adjustment.

And then the second, there are some items in the About You section, so after they finish the item measure questions, they go to an About You section. And one of them ask about - after they've asked about their overall general health like an SF-36 format, then they are also asked about their overall mental

health. And so the respond they can respond about is it, you know, excellent, very good, good, fair, poor.

Lee Partridge: Okay.

Sherrie Kaplan: Thanks.

Lee Partridge: Further questions or comments?

Ann Monroe: This is Ann. You mentioned that it cost $3,000 to conduct the survey. Did I hear that right? What is that for? $3,000 per person, $3,000 for …

Woman: Oh, $3,000 for the agency, so data collection, but that's on assets. Yes. Thank you.

Ann Monroe: $3,000 for who the (unintelligible)?

Elizabeth Goldstein: Per agency …

Ann Monroe: (Unintelligible)health agency?

Elizabeth Goldstein: … for the annual data collection.

Ann Monroe: Okay. And then there's - in some of the material that we got, it talks about racial and ethnic breakdown of participants. Could you talk just a bit about that? Do you have data or how do you account for that?

Elizabeth Goldstein: Yes, we have this …

Woman: (Unintelligible).

Elizabeth Goldstein: … in the packet, but, Wayne, do you want to talk a little bit about that?

Wayne Anderson: Sure. We have that information. We do not case mix control using it. We have done some analyses in the past that look at that, and there are small differences according to race. I don't think they're large on average. You know, there's somewhere around one to two percentage points.

If you were looking at an agency level score, so some race categories do a little better than others. For example, Asia, I believe, is one where we see a difference. And so we have the information. We don't case mix adjust for it. And there is that issue of people, you know, being able to report their race as they want to report it and people can report multiple races. So that's why we do not do anything to try to control for it.

We just have some data. We do observe it. We do report that to our - in the disparities report is what they call it. But, you know, it's just another type of variation that we see daily.

Elizabeth Goldstein: So our case here puts out a report that looks at disparities of care. So home health caps have been in it for, you know, many years. And so they do see when they look at it in terms of closing gaps and all of that, they do see, you know, for some of the home health cap measures, in particular, the individual items - (unintelligible) individual items that make up the multi-item measures improvement.

Lee Partridge: Right. Are we ready to vote? Okay.

Man: Yes.

Lee Partridge: Ready? Jordan?

Samuel Stolpe: We'll go ahead and open up now. Thank you.

Jordan Hirsch: Voting for evidence for NQF 0517, cast on healthcare survey is now open. Your choices are A pass and B no pass.

Voting for evidence for 0517 is now closed. The committee has chosen to pass with 14 votes for pass and one vote for no pass.

Lee Partridge: Okay. Moving on importance. I'm sorry, yes, performance gap.

Dawn Hohl: This is Dawn. Just a few other comments, we've really touched upon those, the disparities. So thank you for that information.

The one comment that kind of stuck with me in the review was, in the respondents, 3% of patients responded as non-English. So it leads us to question the accuracy of the patient self-reporting. So I don't know what to do with that piece of information, but it leaves me with that question.

The other comments is that in terms of demonstrating quality problems and opportunity for improvement, the main scores for the five domains had wide ranges, 77% to 88% with the top box scores. And, you know, (roll data) ranges from zero to 100. So I think the data clearly suggests there is room for improvement here.

And I think Wayne really addressed the questions about the minority groups in the race information that - or other questions, so I think that's been address. So they were the only comments that I had.

Lee Partridge: Thank you, Dawn. Before we - I know we got a couple of those cast, but are there any other comments before the rest of us cast our votes? If not, voting then is open.

Jordan Hirsch: Voting for performance gap for 0517 is now open. Your choices are A high, B moderate, C low or D insufficient.

Voting for performance gap for 0517 is now closed. Performance gap has passed with one vote for high, 13 votes for moderate, one vote for insufficient.

Lee Partridge: Okay. Moving on to scientific acceptability. Dawn, do you have any issue here?

Dawn Hohl: I'll be very brief. The Scientific Methods Panel gave this reliability a high rating. They included the (ICC) results, which were very strong.

The one area of concern when you had a sample size less than 50, but I also know for HHS the sample size response is, I believe, 59 or greater, so I'm not sure how relevant that is. So, you know, I don't want to spend a lot of time because the Scientific Methods Panel, you know, did rate this as high.

Lee Partridge: Any other comments? Okay. Voting is now open on accepting the methods panel rating for reliability, which was high.

Jordan Hirsch: Voting on whether or not to accept the Scientific Methods Panel rating for reliability for 0517 is now closed. The committee has voted unanimously with 15 votes for yes to maintain a - to accept, I should say, sorry, the Scientific Methods Panel for high for reliability.

Lee Partridge: Moving on to the second part, validity. Dawn?

Dawn Hohl: Okay. So for validity …

Lee Partridge: Go ahead.

Dawn Hohl: … the - oh, I'm sorry.

Woman: I'm sorry.

Dawn Hohl: Okay. Go ahead.

Woman: (Unintelligible).

Dawn Hohl: Okay. I was hearing the echo, sorry. The Scientific Methods Panel voted this as moderate was one high for moderates and one insufficient. I think it was a lot of the same issues that have been discussed in the other cap survey. There was construct validity using CFA analysis with correlation. But - and I'm not the NQF expert on this, but that's not the typical approach. But with this patient population, it seems to be the best approach there was.

I think there was also some concern about exclusions as well some of the risk adjustment, which I can get into, you know, in a separate discussion if anybody else wants jump in now. Okay.

The questions under exclusion, and I heard the discussion in the renal population with, you know, taking out hospice patients, in this group, there was some concerns with patient dementia and cerebral degeneration, schizophrenia whether or not there should be some critical factor analysis for that. And also - where is the other one? There was another one. Oh, in

hospice, that was the other discussion point, which I think we've already touched on. I think that's it.

Lee Partridge: Okay. Developers, do you want to respond? (Liz)?

Wayne Anderson: Can the speaker please, you tailed off right after you said the word "schizophrenia" and "dementia." Can you finish your phrase again so I hear it please?

Dawn Hohl: Oh, sure, I'm sorry. I realize the other exclusion discussion point was hospice patients being excluded, but I think we've already touched upon that in the renal cap survey. I think you - that was already touched upon.

Wayne Anderson: That's right. So what was the issue about dementia and schizophrenia?

Dawn Hohl: Was - let's see. I'm going back to my notes here. Let's see, exclusions - okay, the risk adjustment for that population.

Wayne Anderson: Well, we are risk - this is Wayne Anderson from RTI. We are risk-adjusting for that population. We ask all HHAs, home health agencies, to provide the top five diagnoses that they treat for. And those two routinely are part of those patients' diagnoses. You can't prepare a treatment plan for someone who's at home receiving home healthcare without paying attention to those cognitive and behavioral issues. And so we routinely get those and we control for them in patient mix. And it - they are …

Dawn Hohl: Yes.

Wayne Anderson: … huge effects for schizophrenia that's about four percentage points adjustment one way. And then for dementia, I believe it's somewhere around two percentage point adjustment. So it's definitely a meaningful …

Dawn Hohl: Okay.

Wayne Anderson: … contribution to be able to control for that.

Dawn Hohl: Okay. And I'm not going to try to go through the whole packet, but I think in the Scientific Methods Panel, there was a reference that the R-squared values were very small. So I don't know if that has meaning to you, Wayne, but I think that was the bottom line question there or comment from SMP.

Wayne Anderson: I saw that comment, and I'm not, you know, quite sure what you would consider to be large or even moderate R-squared values. I think it's difficult to - in patient satisfaction measures to really dig down and find things that you want to back out of the (S.I.), what our case …

Dawn Hohl: Right.

Wayne Anderson: … adjustment is doing. And so …

Dawn Hohl: Right.

Wayne Anderson: … we have run numerous analyses, you know, different ways looking for things that we could find to back out. And this was essentially the best that we could do. It's not like we haven't tried and gone through multiple different ways for doing it. For example, we matched to all diagnoses back when we were developing the survey with another experiment. We went back to the clinical record and got all the diagnoses. We tested them all.

And frankly, we also were surprised that the only two that really came up with the significant bang for the buck were schizophrenia and dementia. We are doing …

Dawn Hohl: Yes.

Wayne Anderson: … you know, heart - congestive heart failure, COPD, kidney disease, cancer. All of those would have had some kind of a larger degree of measure and they did not. It was just these two - dementia and schizophrenia - that have had an effect.

One thing we did observe and that other people have been spotting this also, before ICD-10, you know, there were fewer dementia codes. But with ICD-10 now, there are more. And we're picking up a greater proportion of people with dementia, almost double what we used to. So we feel like just with these two, we are definitely meaningfully controlling for those issues.

Woman: Go ahead.

Dawn Hohl: And I also further wonder if - who is completing the survey. You know, with dementia, you're more likely, of course, to have the caregivers who may have a little bit more, you know, quote/unquote, "tiredness factor" as well, you know, contributing.

Wayne Anderson: I think that's true. And, you know, I'm looking it up just really quickly to see what our proxy rights are unless (Liz) knows what they are off the top of her head.

Elizabeth Goldstein: About 12% are done by proxy.

Dawn Hohl: Okay.

Wayne Anderson: Yes, that's right. So I mean, you might think that's small but, you know, given this population, I think that's meaningful here. You know, we have the average - the modal age group is about 65 to 74, that range. So I think, you know, that - that's not necessarily the - where dementia makes its biggest contribution. It's in those older ranges …

Dawn Hohl: Right.

Wayne Anderson: … where there's fewer people. So I think our data kind of, you know, see that.

Dawn Hohl: Right, right. And, you know, the last question, I don't know if it falls here or elsewhere. There was a discussion in the HCAHPS group about the removal of the pain questions. Within the HCAHPS survey, there's still a pain question. So I was curious whether or not there's discussion on removing that one as well.

Lee Partridge: (Liz)?

Wayne Anderson: (Unintelligible).

Elizabeth Goldstein: Right. At this point, there's one question on the survey. We are considering in the future taking it out, but nothing has been finalized at this point. Here …

Dawn Hohl: Okay.

Elizabeth Goldstein: … (unintelligible) a little different there. It was - there was concern, you know, about opioid prescribing, whether it was valid or not concern. We can argue about here, the home health agency doesn't prescribe medications, so I think, you know, it's a little different but …

Dawn Hohl: Right.

Elizabeth Goldstein: … you know, we're not sure of what's going to happen in the feature that - to that particular question.

Dawn Hohl: Okay, thank you.

Lee Partridge: Thank you. Excellent. That did stimulate a lot of discussion earlier, and I have that information. Are we ready to vote on validity? We got - yes, okay.

Jordan Hirsch: Voting for whether or not the committee will accept the Scientific Methods Panel's rating of moderate for validity for 0517 is now open. Your options are yes or no.

Lee Partridge: Jordan, I'm coming - my - I'm showing high moderate.

Jordan Hirsch: Is anyone else seeing what Lee is seeing of options that are beyond yes or no?

Man: No.

Woman: (Unintelligible).

Woman: No.

Man: No. Yes or no.

Man: No.

Lee Partridge: All right. It must be my phone just stopped being smart. And you record me as a yes?

Samuel Stolpe: Yes, we can.

Lee Partridge: Thanks.

Jordan Hirsch: Voting is now closed, and the committee has unanimously voted yes to uphold the Scientific Methods Panel's rating of moderate for validity with 15 votes.

Samuel Stolpe: Thank you.

Samuel Stolpe: Okay. Lee, you want to take us to feasibility?

Lee Partridge: I will. Dawn, back to you.

Dawn Hohl: Okay. The only comment under feasibility, which I think someone mentioned a number, there was no description of burden to the agency. So I think a number of $3,000 and I presume that's truly the vendor cost, not the total administrative cost. So it was very hard to rate on this one without that information.

Lee Partridge: Which we now have.

Dawn Hohl: Yes.

Lee Partridge: All right. Any discussions about feasibility? If not, moving on to vote on feasibility.

Jordan Hirsch: Feasibility for 0517 is now open. Your options are A high, B moderate , C low or D insufficient.

Samuel Stolpe: And, Lee, if you're still having trouble, you can either text us - text or chat your vote for us to log for you.

Lee Partridge: No, my machine woke up and decides to behave.

Samuel Stolpe: All right. And sometimes they just stop loving you for a minute.

Jordan Hirsch: Voting for feasibility for 0517 is now closed. The committee has voted to pass feasibility with 11 votes for moderate and four votes for low.

Lee Partridge: Okay.

Samuel Stolpe: Right. Feasibility and use.

Lee Partridge: Moving on to our friend, usability and use, beginning with usability.

Dawn Hohl: So use, we have Home Health Compare. We have this data built into value-based purchasing. The comment we talked about earlier was there was no specifics include about any of the feedback which left us kind of, you know, wanting more information as well as on comments that were provided. Any variation between vendors and administration, that was one of the questions asked. But overall, I think we've already touched upon all these points.

Lee Partridge: Any further comments or discussion?

Stephen Hoy: Yes, this is Stephen. And the developer …

Lee Partridge: Yes.

Stephen Hoy: … mentioned earlier that some of the home health agencies have now began quality improvement programs. To what extent are they using this data?

Lee Partridge: (Liz), can you answer?

Elizabeth Goldstein: Yes. We don't - this is (Liz). We don't get data directly back from each home health agency. But from what we're hearing from agencies in the industry, I think most are using the data and most of the vendors have set-up, you know, advice for quality improvement so that would take particular measures and say, you know, have done research and say, you know, given advice about what they can do to improve, you know, the particular score.

Wayne Anderson: This is Wayne Anderson again. You know, home health is different and that it's not just a patient, you know, who may try to go identify home health agency either through word of mouth or through these caps, ratings and things. A lot of referrals particularly for the large group of patients that are in hospitals first for an admission are done by the social workers or other staff at discharge. And so I think the agencies are really cognizant of wanting to get those referrals. And one way that you can get those referrals is if you have that relationship with the discharge planner and have some factual data to back up the fact that you might know do a good job.

Hospitals may refer to their own affiliated home health agency, but they also refer to other agencies in the community, particularly where people live. So I

think there's an onus on the agencies just to be able to do this so that they stay in the good graces of the people who were giving the referrals.

Lee Partridge: Okay. Further discussion on usability? If not, are we ready to vote? Jordan?

Jordan Hirsch: Voting on use for 0517 is now open. Your options are A pass or B no pass.

Lee Partridge: Oops.

Peter Thomas: Lee, I just got dropped. I vote pass. This is Peter Thomas. I got to get back on to the voting platform.

Jordan Hirsch: Thank you, Peter. It looks like we're waiting for - I don't know, sorry, with Peter's vote.

Peter Thomas: Back up - I'm back up. I just said pass.

Jordan Hirsch: Fantastic. Thank you. Voting for use is now closed. The committee has passed use with 14 votes for pass and one vote for no pass.

Lee Partridge: Okay. Moving on to usability, Dawn, any final thoughts here?

Dawn Hohl: No, I don't think I have anything to add here.

Lee Partridge: Anybody else?

Jordan Hirsch: Hearing no other comments, voting for usability for 0517 is now open. Your options are A high, B moderate, C low or D insufficient.

Voting for usability for 0517 is now closed. Usability passes with one vote for high, 12 votes for moderate, one vote for low and one vote for insufficient.

Any comments before a vote for overall suitability for endorsement?

Dawn Hohl: This is Dawn. I don't have anything to add.

Jordan Hirsch: Thank you. Overall suitability for endorsement for 0517 is now open. Your options are A yes or B no.

Voting for overall suitability for endorsement for 0517 is now closed the committee recommends 0517 for maintenance of endorsement with 14 votes for yes and one vote for no.

Lee Partridge: Right. Thank you, CMS and RTI. Long discussion but a good one. Next up and I'm looking at the clock, but I hope we can get through at least 2632 by four o'clock. I'm not sure, but that's - that would be our goal. Otherwise, we will resume the discussion tomorrow afternoon.

Okay. 2632 and our developers, are you on the line?

Woman: Yes, this is (unintelligible).

Lee Partridge: Okay. Would you like to introduce the measure and explain?

Woman: Yes, thank you so much and I will be brief given the timing.

Man: Right.

Woman: So this is the change in mobility measure for patients requiring ventilator support at the time of admission. This is a measure that was initially endorsed in 2015. And just in terms of what the actual measure is, it's the change in mobility scores between admission/discharge. There are eight mobility items that are scored at admission/discharge and we look at the change between admission/discharge.

Theoretically, patients could gain as much as 40 mobility units or lose as much as 40 mobility units. And this is a measure that's focused on again the LTAC space and it is a risk-adjusted measure. The measure was implemented by CMS as required by the Bipartisan Budget Act of 2013 that Congress passed. This is also known as the Pathway to SGR Reform Act.

For those not familiar with LTAC, there's about 430 of them in the U.S., and they are hospitals that take care of patients who are chronically critically ill. There's generally not a lot of literature published related to LTACs, and so in addition to the LTAC literature, we also did pull some of the early mobilization research conducted in ICUs for ventilator patients as part of our background material. This measure was implemented in 2016, as I said, in response to the law that was passed. And the time frame for this measure is 24 months.

In terms of gaps, we did find disparities in two groups, individuals who are black or African-American had lower change in function related to our reference category of people who are white. And we also found on the payer side that patients with Medicaid managed care had birth functional scores or less improvement in patients who have private insurance. Many of the specifications for this measure are aligned with the measures that we discussed in 20 - or on in the in-person meeting on 06/20.

And just to wrap up, public reporting for this measure is - was finalized by CMS through rulemaking to occur - starting next year with data from 2018, 2019 on CMS' LTAC Compare website.

I'll turn it over to Dr. Alan Levitt who may have some additional comments.

Alan Levitt: Okay. Yes, thanks, (Diane). I'll be really brief, too. And just to reiterate, the - in terms of the general considerations we have for measures that we developed and measures that we adopt in our quality reporting programs, I think as I mentioned before the last meeting, we do - I shall answer to a higher authority. And this is a measure. (Diane)said that Congress mandated for us on the last page over the 1,200-page (unintelligible)that said we should be doing - establish a functional status quality measure for changing mobility among in-patients requiring ventilator support. And so this measure is really in response to that.

That's it. Turn it back over to Deb.

Deb Saliba: Thank you. And our lead discussant here is Dr. O'Malley.

Terry O'Malley: Thank you very much and - Dr. Levitt. I'm glad you read all the way through the 1,200 pages.

So this is an interesting measure. It's one of the first - the other I think it's (unintelligible) is that it is one of the first using the (G.G.)codes for functional measures. So again, these are the codes that are common now across all the federally-mandated assessment instruments. So it's sort of an interesting start to a new class of measurement using these new codes.

I have - I don't want to rehash everything we went over from the in-person meeting. But there are a couple of questions I would appreciate some help on some clarity. One has to do with the - there was a graph showing the measures for stable over sort of rolling quarters. And I wasn't sure how to interpret that. On the one hand, it's nice to see a measure stability. But am I confusing that with demonstrating a change in the mean. You know, so is there - is there a measurable change in the performance based on interventions that are being done? And where would we see that change? Appreciate your help on that.

Ann Monroe: Sure. So this is Ann. I can start - give an answer for that. So I think Peter Thomas mentioned in the in-person meeting that function tends to be a little bit harder maybe than other measures to show change over time. And so I think that is the case. You know, this measure was just implemented in 2016. And the LTAC has started receiving internal report since 2017. And so it's still fairly new. The data that we report on goes through a bit of 2018, but not obviously the entire year, yes, because some of that is still open for providers.

So we've not - your interpretation of the data is correct. We haven't seen significant change. There has been perhaps a little bit of improvement that's starting to happen, but it's certainly not a trend at this point. And one of the reasons that we think that we're maybe not seeing so much movement at this point is that LTACs did have some payment reform. At the same time, as (Alan)mentioned, when this law was passed there were some payment reforms, and so those have been in effect. And so I think the LTACs have been busy dealing not only with quality issues, but also payment changes for their setting.

And, Alan, do you have anything else to add?

Alan Levitt: No. Thanks, Ann. Yes, just to reiterate again, the site-neutral payment was initiated in this and kind of phased in. And so in the industry know, there's been a lot of change in the industry associated with that. And so it is something we'll continue to monitor, but then sometimes you don't have a choice to have quality measures. It's just what else may be going on externally. That could also be influencing how measure resolved.

Terry O'Malley: Great. And just a couple other comments, again, these are more from the reviewers and the Scientific Methods Panel, but they - just to raise them and have the responses that I think were made perhaps previously.

One was - a question was raised about a scoring for activity not attempted, which also included patient refused, not applicable, not attempted to do environmental limitations or medical condition or safety concerns. And that was a concern of one reviewer. However, you all presented data that showed this was a very small percentage of patients. And that missing data on this question was quite low. And I just want to confirm that's the case.

Ann Monroe: So the missing data is indeed very low. The activity not attempted code indicate often that patients are basically too ill to perform the activity. So, for example, somebody who has, you know, multi-organ failure may not be actually doing ambulation especially at the time of admission. And so the codes that we have for the activity not attempted code sometimes indicates the person is too ill, and that's actually this main - the main reason that those codes get used 88 and 09. We don't see a lot of Code 7, which the patient refused or Code 10.

Terry O'Malley: Great. And another comment was made about the exclusions, which all are sort of the usual and reasonable ones and complete stays, hospice, progressive neurological diseases, coma, younger than 21 because they don't have

performance data and independent on admission. So they're all reasonable. It turns out that the exclusions account for 37% of the population, most of which was due to incomplete stays.

And the only comment was it'd be interesting to see if exclusion rates, particularly for incomplete stays, very significantly across facilities. And whether it's really an indication of sort of a very different case mixes. Any thoughts on that?

Ann Monroe: Sure. So there is variation across LTACs in terms of the percentage of patients who have incomplete stays. I think we did talk about this in-person. Basically, if somebody has a medical emergency, CMS does not expect a functional assessment to be completed at that point in time. And so there is, you know, basically not a requirement to do that if there is a medical emergency.

There is another quality measure that does address whether patients perhaps have been discharged to acute care. They discharge to community measure, for example, is the LTAC quality reporting program, so that would basically pick up any quality issues related to a high number or a high percentage of incomplete stays.

Alan, did you have anything else to add?

Alan Levitt: Oh, I'm sorry. No, no. Just exactly (unintelligible). Thanks, Ann.

Terry O'Malley: Great. So just to quickly move onto Criteria 1, important measures, the evidence was updated. There's a logic model, some literature cited although there's scant literature for LTACs per se. There's comparable ventilator data

from other sites, which certainly supports early intervention with re-identification services.

And the feeling of the Scientific Methods Panel was that the evidence was better and direction was the same, not needed to be discussed. But there is a high gap in care with an opportunity for improvement and if there were disparities noted, particularly based on marriage status, and race, and payment source not on ethnicity. And the Scientific Measurement Panel voted that as a pass. So stop at that point.

Lee Partridge: All right. Sherrie and Deb Saliba were also reviewers here. Any - do you have anything to add?

Sherrie Kaplan: Only - just to follow-up, the one - 299 of 750 patients, and I wasn't involved in the - in the review of this on the Scientific Methods Panel, so I have a question back to the reviewers about the representativeness, when almost half of the population gets excluded, one wonders a little bit about generalizability of findings. And first of all, congratulations on a very thorough analysis. I mean, this is a great thorough analysis. So I have two quick questions.

One is about representativeness of the sample, and the second one is about what we've been discussing about the within versus between facility variation, including an error term that are cross-items for a multi-item scale within a patient. And then within patient variations across patients within a facility and then between facility variation. So can you just give us a sense of what you think about the representativeness given the exclusion?

Ann Monroe: So I think, you know, given that we're not in a position to ask the providers to do a functional assessment when the person is having a medical emergency,

perhaps we can think of this measure as basically representing people who had completed stays for the most part who that aren't inclusion criteria.

As I said, you know, the church and community measure, I think, compliments this measure to give us this other aspect of what is going on at the facility. You know, the patients that I mentioned are quite ill, many having multi-organ failure. And so asking the providers to provide functional assessment data when the person is having a medical emergency on top of that, I think, is a bit of a challenge.

So does that address, Sherrie, your comment, at least your first comment to that?

Sherrie Kaplan: Sure, sort of, there's not much you can do about it. It sounds like one was curious. So the reviewers of the Scientific Methods Panel raised that issue of representativeness then of the sample to the population of facilities dealing with this issue. But it doesn't sound like there's much to be done about that other than make a comment on it.

So then the other question I had is probably not fair to ask you because it's not part of NQF's current criteria for inter-class correlation coefficients and you did the version that's being required, so forget the second one. But I did have a question about the magnitude of the change with respect to the standard error around the ever-changing mobility because some of these look pretty small. How much does it need to get a real clinically meaningful change?

Ann Monroe: Great question. So in general, you know, just estimates we think - because we do have a fairly large sample, as you know, so we do see a lot of statistical significance even with very small changes. So we kind of estimate that when we see about, you know, 0.8 to about one unit of mobility change, that's

probably clinically significant. We're still working on some of those analyses, but that's kind of based on our analysis of the data so far.

Sherrie Kaplan: Thank you.

Lee Partridge: Okay. Deb?

Man: Okay.

Man: Just a quick note to the Chair, we had a comment from Don Casey in the chat that we would like to share at the appropriate time.

Lee Partridge: All right. Deb Saliba? Deb not with us. I know Chris Dezii is on.

Man: Yes. So yes, Deb didn't answer to roll call, so I don't think that she's here.

Lee Partridge: All right. Then Don's question or comment.

Jordan Hirsch: Don would like to know if the developers can provide trends for the inter-quartile range for the years available for this measure?

Ann Monroe: Sure. We - I don't have that immediately. Is that something that we could provide to you within the next week or so or …

Lee Partridge: I'm turning to staff for help here.

Man: Sure.

Lee Partridge: I think you - essentially you don't do that.

Man: I suspect that we'll - the answer to the question is no, at least not relevant to this particular submission.

Lee Partridge: Okay.

Man: So we should - we should either accept that it's not currently available and maybe not entirely necessary for us to make a decision or request the developer to provide it with the subsequent submissions if you feel like that would be appropriate.

Ann Monroe: Okay. We did provide since we had, you know, this is a 24-month measure, we did provide the data by quarter so that you can see at least changes over time. As I indicated before, there is a bit of movement from 9.0. It went up a little bit to 9.7 at one point, so - but there's not a clear trend, but there was definitely some movements.

Lee Partridge: Right. Are there survey comments or questions from the rest of the committee? I'm looking at the clock and I'm very happy what Chris did on Friday. If we can all stay for just a little bit longer, I think we can finish this measure today.

Man: I'd love to do this, Peter. I'd love to do this, but I'm - but I'm afraid I have a four o'clock …

Lee Partridge: Yes.

Man: … that I can't move.

Lee Partridge: We'll have a hard stop at four. Do we lose our quorum?

Lisa, we still have you?

Lisa Gale Suter: I also - this is Lisa Suter, not Lisa Morrise, but I also have a hard stop at four.

Samuel Stolpe: (Unintelligible).

Lee Partridge: Okay.

Samuel Stolpe: Yes. Then let's go ahead and close out …

Lee Partridge: Is that Sam?

Samuel Stolpe: Yes, my recommendation would be to finish out those criteria and then we can revisit the remainder on our subsequent call.

Lee Partridge: I'm sorry, I didn't hear the first part of your question.

Samuel Stolpe: Oh, yes, let's …

Lee Partridge: (Unintelligible).

Samuel Stolpe: … is to finish out this - the vote on this particular criterion. And then …

Lee Partridge: All right.

Samuel Stolpe: … let's go to public comment and we'll finish up the remainder of this measure in our call tomorrow.

Lee Partridge: All right. So our first vote would be on importance, right?

Samuel Stolpe: That sounds good. Yes, let's go head and vote.

Jordan Hirsch: Voting for evidence for 2632 is now open. Your options are A high - I'm sorry, A pass or B no pass.

Voting is now closed for evidence for 2632 with 14 votes for pass and one vote for no pass. Evidence passes for 2632.

Samuel Stolpe: All right, very good. If the committee feels like there's no need to discuss performance gap any further, we can go ahead and vote. Otherwise, let's just - let's just go ahead to move to public comment.

Man: I have a quick note about gap.

Man: Okay, thank you.

Man: That's the issue, right?

Samuel Stolpe: Yes.

Lee Partridge: Yes.

Man: Ann, let me ask you - sorry, Dr. (Deutsch). Let me ask you, isn't this measure a bit different in terms of gap than say a process measure where you're trying to get as many patients in IRS to receive the influenza vaccine where you want to see over time compliance with that measure and thereby, the gap kind of goes away or gets much smaller and thereby maybe is not such an important measure anymore. This is a measure that applies to each individual and assesses their function and their functional improvement throughout their

stay. And I wouldn't expect that you'd see a - the same kind of dynamic as you would see with that kind of a process measure. Am I right about that?

(Deutsch): We - yes, I would say that our goal would be to reduce the gaps and, you know, we do see disparities so we do see gaps in care. And so improving so that everybody is improving as much as possible would certainly be the goal.

Man: Okay, I see what you mean, yes. Okay, thanks.

Lee Partridge: All right. Are we ready to vote on gap, on B?

Jordan Hirsch: Voting for performance gap for 2632 is now open. Your options are A high, B moderate, C low or D insufficient.

Voting for performance gap for 2632 is now closed. Performance gap passes with one vote for high, 11 votes for moderate, three votes for low.

Lee Partridge: Okay. And with that, we will stop there and go to public comment and plans for tomorrow.

Samuel Stolpe: Very good, thank you. Public comment now open if you have a comment either from the public or the membership, please feel free to share it now. You may also enter anything through the chat, which will be read by NQF staff.

All right. Everyone enjoys an awkward pause. Let's go ahead and move on to our project time line. No comments from the public at this time.

Jordan Hirsch: All right. We are moving on to next steps. Tomorrow we will have another call. It'll actually be Post-Measure Evaluation Web Meeting number 3 from 1

to 3 p.m. Eastern where we will pick up with reliability on 2632 as well as finish 2635 and 2636 on the call. And then we will have public comment in August and the draft report will be - I'm sorry, the draft report post comment call will be on September 25th from 1 to 3 p.m. Eastern.

Samuel Stolpe: Very good. Thank you, Jordan. All right. Well, this concludes our call for the day. From myself, Sam Stolpe, and the rest of the NQF team, a very big thanks to our co-chairs and to the committee for all your hard work on this call. And also a big thanks to our measure developers and stewards who were kind enough to join to discuss their measures with us. Thanks everyone for your time. We look forward to continuing the conversation tomorrow.

Any closing words from you, Lee?

Lee Partridge: I just want to echo to thank you. This is a long hard slug and I appreciate both the developers and the committee's patience. We hope we never have quite this kind of push again.

Samuel Stolpe: All right. But …

Lee Partridge: But we'll talk one o'clock tomorrow.

Samuel Stolpe: All right. So one o'clock tomorrow. Thanks everybody. Bye.

Man: Thank you. Bye.

Man: Thanks. Have a good night.